California MEDICINE

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# EDITORIAL

## A Guide for Fees

NEARLY ALL the confusion and many of the economic injustices resulting from poorly designed fee schedules can now be ended. The way to this most desirable goal has been cleared by the C.M.A. Council's official adoption of standards for fee schedule nomenclature and relative values. These standards are contained in a Relative Value Fee Study report just made by the Committee on Fees of the C.M.A. Commission on Medical Services. The report will be found on page 211 of this issue of CALIFORNIA MEDICINE.

In its study the committee had no intention of setting anyone's fees or anyone's schedule of fees. The relative value study is in no sense a fee schedule. It sets forth relations existing between fees in California. Listing no fees in dollars, it sets no fees.

The need for such standards has long existed. Without a common nomenclature, it has been next to impossible to evaluate and compare fee schedules one with another. Without a listing of correct relative values of fees, health insurance schedules have inevitably paid too much for some procedures and not enough for others. Neither individual nor group purchasers of indemnity insurance have had understandable guides to the determination of the adequacy of their coverage—guides by which a layman, examining an insurance policy, can determine which of a long list of wholly unfamiliar medical and surgical benefits can be expected to pay a greater or lesser part of the physician's fee. Physicians have found it necessary to examine each fee on each new fee schedule issued by an insurance company in order to determine its degree of acceptability to them. The profession has demonstrated fault in every fee schedule yet produced, even the schedules designed by C.M.A. committees for California Physicians' Service. In the absence of standards, confusion, disappointment with health insurance, and economic injustice for physician, for insured patient or for the insurance company have been the rule.

The medical profession, and not insurance companies or others, should set standards for fee schedules. As observed by Francis J. Cox, M.D., chairman of the committee that has struggled with this assignment since August, 1952, "It is the exclusive right and the exclusive duty of physicians to set and interpret fees."

The nomenclature adopted as standard followed a pattern developed by Blue Shield-Blue Cross nationally. The standards for relative values of fees were established by survey of the membership of the California Medical Association.

Now that standards of nomenclature and relative values have been officially adopted by the profession in California, we hope for and urge their early use by everyone concerned with setting up fee schedules and health insurance indemnities, by everyone who buys, sells or administers health insurance or who controls other private and public plans and mechanisms through which money is paid for the services of doctors of medicine.

If widespread conformance to these fee schedule standards does follow C.M.A.'s action, here are some of the principal advantages that can be expected:

1. Anyone who is familiar with one fee schedule could at a glance evaluate another. By looking at only one fee in each of the four sections of the schedule—medicine, surgery, radiology, pathology—one would know immediately how high or low the entire schedule had been set, for each fee is related to all others in the schedule. We would no longer have to look at every procedure, examine its definition, evaluate each payment allowed.

2. Prospective purchasers of indemnity health insurance could quickly compare benefits of one policy with those in another and could estimate approximately what part or percentage of medical and surgical costs in his community would be paid by the insurance benefits offered. For example, if he knew that the going fee in his area for appendectomy is

$200 and the proposed insurance pays $150 for that procedure, he could expect to pay around one-third more than his insurance benefit for any other surgical procedure. He would not find himself with a schedule of benefits that bear little relationship to physicians' charges, as he often does today.

3. Once the better insurance companies adopt C.M.A. standards for their indemnity schedules, purchasers of health insurance will learn to stop buying plans that tend to mislead by displaying large cash benefits for procedures that are rarely performed, but allow small benefits for procedures frequently performed. We could even hope to see a legend such as the following printed above indemnity schedules in insurance policies: "Prepared in accordance with the nomenclature and relative value standards of the California Medical Association."

4. C.P.S. fee schedules can be revised to reflect the relationship between fees which exists in practice throughout the state. The relative values reported by the Committee on Fees are based upon the fees charged in their practices by the forty-seven hundred California physicians who responded to the committee's survey.

There are other valuable applications of the relative value study. A physician coming into a new community will now need to determine the fees charged by local physicians for only a few procedures in order to set up his own complete schedule of fees, using the relative value study as a guide. County society public service committees can use the C.M.A. study to determine the reasonableness of a fee about which a patient has complained, relating it to other fees charged in the community. Many physicians will reexamine their own fees for some procedures in terms of relative values established by the statewide study. The study can also be used to demonstrate inequities in fee schedules now used by certain government agencies, with request for revisions.

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The Committee on Fees had many good reasons for expressing relative value standards for fee schedules in units rather than in dollars. Here are four:

1. The level of fees varies throughout the state under the influence of many factors. But analysis of the survey results reveals that the *relationship* between fees for most procedures remains almost the same, even in widely separated geographical areas. Expressed in dollars, these relationships would have been misleading and incorrect for many areas. Expressed in units, they are accurate and useful.

2. Health insurance in California today requires fee schedules and indemnity schedules at many different dollar levels. C.P.S. needs different fee schedules for different income ceiling plans. Many groups want to buy indemnity insurance that pays benefits approximating the usual fees charged by physicians. Others want adequate protection at a low premium and will accept an element of co-insurance. This is achieved in health insurance by setting the indemnity schedule at a dollar level that is lower than the fees the insured knows he will have to pay his physician. The relative value study, expressed in units, may be used as a guide in setting any and all of these schedules with widely varying dollar levels but retaining a constant relationship between fees so that everyone —physicians, patients and insurance companies— can tell at a glance just how much higher or lower each schedule is.

3. The relative value schedule will require change to keep abreast of the changes in medicine. New procedures are introduced. Others become obsolete. New methods of doing the same procedure increase or decrease the amount of time or skill required, with a resulting change in the compensation the physician should receive for the service. Changing a fee schedule expressed in dollars is difficult and often requires years of work and negotiation. The relative value study, expressed in units, can readily be changed by the results of new surveys from time to time, which are recommended by the Committee on Fees. Thus the standards can be changed to reflect new facts of medical practice. Changes in the dollar schedules can follow one by one.

4. The Commission on Medical Services wanted to avoid any implication that it is setting the level of anyone's fee or fee schedule. The relative value study is in no sense a fee schedule. It reveals relations existing between fees in California. Listing no fees in dollars, it sets no fees.

The relative value study is a significant contribution to health insurance and to all who are concerned with it—physicians, insurance companies, C.P.S. and most of the people of California. We believe Dr. Cox and his committee will soon realize their hope "that it will make good, adequate insurance, which allows free choice of physicians, easier to produce, buy, sell and administer . . . that it will be used to eliminate some of the obvious inequities in all fee lists."

## Salk Vaccine, 1956

IN LIGHT OF REPORTS that the incidence of poliomyelitis was less in children who were injected with the Salk vaccine last spring, physicians and the general public are keenly interested in the further use of the vaccine that is now being made available, even though wary as a result of the dangers found to be associated with some of the vaccine produced last year by methods that were officially approved at that time.

In these circumstances, physicians are of course